NHS Ayrshire & Arran

12 Hourly Higher Level Supervision Checklist

Write or attach label

CHI No: ……

Surname: ……

Forename: …… Sex: ……

Address: ……

……

Date of Birth: ……

Patient is identified as requiring Higher Level Supervision (HLS)

Please refer to HLS Guideline

Date/time HLS commenced:____/____/____ @ _____am/pm

Level of HLS required: Cohort or Constant (1:1) _____

Person/s responsible for decision: _____

Patient Requires HLS for the following reason (please tick as appropriate)

Patient is at risk of suicide or self-harm ☐

Detained patient ☐

Patient is displaying aggressive behaviour ☐

Patient is at risk of absconding ☐

Patient is mentally unwell and is a risk to self/others ☐

Patient is at risk of falls ☐

Other ☐ Please state reason:_____

Level of staffing required: RGN ☐ HCA ☐ RMN ☐

Additional Comments:

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Date/Time: - - /- - /- - @ - - - - am/pm Continue Yes ☐ No ☐ Signature:
Comments: ____

Date/Time: - - /- - /- - @ - - - - am/pm Continue Yes ☐ No ☐ Signature:
Comments:____

Date/Time: - - /- - /- - @ - - - - am/pm Continue Yes ☐ No ☐ Signature:
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Comments: ____

If HLS discontinued document reason in nursing evaluation record